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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00423

430 CERTIFICATE OF DEATH

Item 2 FilmG238 1-29-59 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CAROLINE</u>		STATE <u>MARYLAND</u> COUNTY <u>CAROLINE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>		STREET ADDRESS (If rural give location)	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL GREENSBORO</u>		LENGTH OF STAY (In this place) <u>4 mos</u>		TOWN <u>DENTON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Daughter's home</u>							
3. NAME OF DECEASED (Type or Print) <u>WALTER JEROME COHEE</u>				4. DATE OF DEATH (Month) <u>JAN</u> (Day) <u>21</u> (Year) <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>June 8, 1870</u>	
9. AGE last birthday <u>88</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM A. COHEE</u>				14. MOTHER'S MAIDEN NAME <u>EMILY GILL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>RAY COHEE, DENTON, MD</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
334X IMMEDIATE CAUSE (A) <u>Arterio Sclerosis General</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs -</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Sclerosis</u>				<u>4 mos</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-10, 1958</u>, to <u>1-21, 1959</u>, that I last saw the deceased alive on <u>1-21, 1959</u>, and that death occurred at <u>8 P.</u>M, from the causes and on the date stated above.							
SIGNATURE <u>Lauren George</u>				DATE SIGNED <u>1-23-59</u>			
M.D. <u>Denton Md</u>				ADDRESS (Street, city, town, state)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 24, 1959</u>		NAME OF CEMETERY OR CREMATORY <u>DENTON</u>		LOCATION (City, town, or county) <u>DENTON, MD.</u>	
24. REC'D BY REGISTRAR <u>JAN 27 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George Moore</u> ADDRESS <u>Denton Md</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00424

431

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Marydel</u>		c. LENGTH OF STAY IN 1b <u>25 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>		d. STREET ADDRESS <u>None</u>	
3. NAME OF DECEASED (Type or print) <u>Cecil</u> First <u>Elliott</u> Middle <u>Demby</u> Last		4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/7/58</u>
9. AGE (In years last birthday) yrs. <u>25</u>		IF UNDER 1 YEAR Months <u>25</u> Days <u>1</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Dover, Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leon Demby</u>		14. MOTHER'S MAIDEN NAME <u>Grace B. Stevens</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Leon Demby</u> Address <u>Marydel, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Principial Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Exposure</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>20</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 31, 1958</u> , to <u>Jan 1, 1959</u> , that I last saw the deceased alive on <u>Dec 31, 1958</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Cecil Elliott Demby</u>		M.D. <u>Richard L. Smith</u> DATE <u>1/1/59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Blanco</u>		22d. LOCATION (City, town, or county) (State) <u>Hartly, Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulaire Greensboro, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 5 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00425

432

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>RAYMOND</u> First <u>RAPP</u> Middle <u>FISHER</u> Last				4. DATE OF DEATH <u>Jan</u> Month <u>11</u> Day <u>19</u> Year <u>59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 10, 1891</u>	9. AGE (In years lost birthday) <u>67</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUS DRIVER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>unknown (orphaned)</u>				14. MOTHER'S MAIDEN NAME <u>unknown (orphaned)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give year or dates of service) <u>WW2</u>				16. SOCIAL SECURITY NO. <u>9</u>			
17. INFORMANT <u>Mrs Raymond Fisher, Denton, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brochial Asthma Chronic</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>10 1/2 hrs</u> <u>4 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Jan 10</u> , 19 <u>58</u> to <u>Jan 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 10</u> , 19 <u>59</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dawson George</u> M.D.				ADDRESS (Street, city or town, state) <u>Denton Md</u>			
DATE SIGNED <u>1/12/59</u>							
PHYSICIAN'S NAME (Type) <u>DAWSON GEORGE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 14, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) <u>Denton, Md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Thompson</u> ADDRESS <u>Denton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00426

433

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henderson</u>				c. LENGTH OF STAY IN 1b <u>50 Yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>A.</u> Last <u>Griffith</u>				4. DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/5/1866</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Luther Griffith</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Tribbett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>222-14-8990</u>		17. INFORMANT <u>Lola Grace Marvel Sudlersville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 1</u> , 19 <u>58</u> , to <u>Jan. 10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan. 9</u> , 19 <u>59</u> , and that death occurred at <u>4:15A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Greensboro, Md.</u> DATE SIGNED <u>Jan. 10 1959</u>							
ACTUAL SIGNATURE <u>Charles H. Stonesifer</u> M.D.				PHYSICIAN'S NAME (Type) <u>Charles H. Stonesifer, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/13/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		22d. LOCATION (City, town, or county) (State) <u>Greensboro, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulais</u> ADDRESS <u>Greensboro, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 14 59</u>		24b. REGISTRAR'S SIGNATURE <u>Robert L. Finner</u>	

CERTIFICATE OF DEATH

188

State, Del. 18

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. SIGNATURE OF PHYSICIAN</p>		<p>10. SIGNATURE OF REGISTRAR</p>	
<p>11. DATE OF DEATH</p>		<p>12. TIME OF DEATH</p>	
<p>13. PLACE OF DEATH</p>		<p>14. SIGNATURE OF WITNESSES</p>	
<p>15. SIGNATURE OF DECEASED</p>		<p>16. SIGNATURE OF NEXT OF KIN</p>	
<p>17. SIGNATURE OF CLERGYMAN</p>		<p>18. SIGNATURE OF JUDGE</p>	
<p>19. SIGNATURE OF SHERIFF</p>		<p>20. SIGNATURE OF CORONER</p>	
<p>21. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>22. SIGNATURE OF COUNTY CLERK</p>	
<p>23. SIGNATURE OF TOWNSHIP CLERK</p>		<p>24. SIGNATURE OF VOTING CLERK</p>	
<p>25. SIGNATURE OF POLL CLERK</p>		<p>26. SIGNATURE OF JURY CLERK</p>	
<p>27. SIGNATURE OF COURT CLERK</p>		<p>28. SIGNATURE OF PRISON CLERK</p>	
<p>29. SIGNATURE OF ASYLUM CLERK</p>		<p>30. SIGNATURE OF HOSPITAL CLERK</p>	
<p>31. SIGNATURE OF NURSING HOME CLERK</p>		<p>32. SIGNATURE OF BOARDING HOUSE CLERK</p>	
<p>33. SIGNATURE OF LODGING HOUSE CLERK</p>		<p>34. SIGNATURE OF ROOMING HOUSE CLERK</p>	
<p>35. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>36. SIGNATURE OF ROOMING HOUSE CLERK</p>	
<p>37. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>38. SIGNATURE OF ROOMING HOUSE CLERK</p>	
<p>39. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>40. SIGNATURE OF ROOMING HOUSE CLERK</p>	
<p>41. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>42. SIGNATURE OF ROOMING HOUSE CLERK</p>	
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<p>45. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>46. SIGNATURE OF ROOMING HOUSE CLERK</p>	
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<p>49. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>50. SIGNATURE OF ROOMING HOUSE CLERK</p>	
<p>51. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>52. SIGNATURE OF ROOMING HOUSE CLERK</p>	
<p>53. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>54. SIGNATURE OF ROOMING HOUSE CLERK</p>	
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<p>57. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>58. SIGNATURE OF ROOMING HOUSE CLERK</p>	
<p>59. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>60. SIGNATURE OF ROOMING HOUSE CLERK</p>	
<p>61. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>62. SIGNATURE OF ROOMING HOUSE CLERK</p>	
<p>63. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>64. SIGNATURE OF ROOMING HOUSE CLERK</p>	
<p>65. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>66. SIGNATURE OF ROOMING HOUSE CLERK</p>	
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<p>71. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>72. SIGNATURE OF ROOMING HOUSE CLERK</p>	
<p>73. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>74. SIGNATURE OF ROOMING HOUSE CLERK</p>	
<p>75. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>76. SIGNATURE OF ROOMING HOUSE CLERK</p>	
<p>77. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>78. SIGNATURE OF ROOMING HOUSE CLERK</p>	
<p>79. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>80. SIGNATURE OF ROOMING HOUSE CLERK</p>	
<p>81. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>82. SIGNATURE OF ROOMING HOUSE CLERK</p>	
<p>83. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>84. SIGNATURE OF ROOMING HOUSE CLERK</p>	
<p>85. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>86. SIGNATURE OF ROOMING HOUSE CLERK</p>	
<p>87. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>88. SIGNATURE OF ROOMING HOUSE CLERK</p>	
<p>89. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>90. SIGNATURE OF ROOMING HOUSE CLERK</p>	
<p>91. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>92. SIGNATURE OF ROOMING HOUSE CLERK</p>	
<p>93. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>94. SIGNATURE OF ROOMING HOUSE CLERK</p>	
<p>95. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>96. SIGNATURE OF ROOMING HOUSE CLERK</p>	
<p>97. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>98. SIGNATURE OF ROOMING HOUSE CLERK</p>	
<p>99. SIGNATURE OF BOARDING HOUSE CLERK</p>		<p>100. SIGNATURE OF ROOMING HOUSE CLERK</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00427

434

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CAROLINE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL DENTON		c. LENGTH OF STAY IN 1b 1 yr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELLA Middle FRANCES Last HACKERT		4. DATE OF DEATH Month JAN. Day 1 Year 1959	
5. SEX 7	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 19, 1898
9. AGE (In years last birthday) 60		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY home	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY? USA	
15. FATHER'S NAME EUGENE BALLAND		16. MOTHER'S MAIDEN NAME STELLA [unknown]	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		18. SOCIAL SECURITY NO. -	
19. INFORMANT Charles Hackert, Denton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X Cardiac Failure DUE TO (b) Carcinomatous DUE TO (c) Carcinoma of the uterus		INTERVAL BETWEEN ONSET AND DEATH 1 week 1 yr - ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-24, 1958 , to 1-1, 1959 , that I last saw the deceased alive on 12-27, 1958 , and that death occurred at 12:05 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE H. R. Trapnell		DATE SIGNED 1-1-59	
PHYSICIAN'S NAME (Type) H. R. Trapnell		ADDRESS (Street, city or town, state) Federalburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 1-3-58	22c. NAME OF CEMETERY OR CREMATORY Loudon Pk. Cem.	22d. LOCATION (City, town, or county) (State) BALTIMORE, MD.
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes		ADDRESS 130 E. Fort Ave.	
24a. REC'D BY REGISTRAR IAN 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

435

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural				c. LENGTH OF STAY IN 1b 23 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Houston Branch Road				d. STREET ADDRESS Houston Branch Road			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Paiza Middle Hrynko Last Hrynko				4. DATE OF DEATH Month January Day 7 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1882	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Ukraine		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Stephen Hrynko, Federalsburg, Md., R.F.D.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY OCCLUSION, ACUTE, TERMINAL 420.1 DUE TO GENERALIZED ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 7 MINUTES 7 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSION; SENILE STATE							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 7/19 , 19 49 , to 1/1 , 19 59 , that I last saw the deceased alive on 1/6 , 19 59 , and that death occurred at 11 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>R. H. Beckert</i> M.D.		ADDRESS (Street, city or town, state) Bridgetown, Delaware				DATE SIGNED 1/9/59	
PHYSICIAN'S NAME (Type) R. H. BECKERT, M.D.		BRIDGEVILLE, DELAWARE 1/9/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF Jan. 9, 1959	22c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cemetery	22d. LOCATION (City, town, or county) (State) Youngstown, Ohio				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR JAN 12 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL	
OCCUPATION		INDUSTRY		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
CONDUCTOR		RAILROAD		HEART DISEASE		SUICIDE		HOSPITAL	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		MANNER OF DEATH		CAUSE OF DEATH	
JAN 6 1963		11:00 PM		HOSPITAL		SUICIDE		HEART DISEASE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		TIME OF SIGNATURE		PLACE OF SIGNATURE		MANNER OF SIGNATURE		CAUSE OF SIGNATURE	
JAN 6 1963		11:00 PM		HOSPITAL		SUICIDE		HEART DISEASE	

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH - BALTIMORE 18

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00429

CERTIFICATE OF DEATH

436

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>CAROLINE</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>DENTON</u> LENGTH OF STAY (In this place) <u>48 yrs</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>CAROLINE</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u> TOWN STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>GEORGE HERMAN KOENIG</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JAN 27 19 59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>APR 4, 1895</u>
9. AGE last birthday <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>restaurant owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>food</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis T. Koenig</u>		14. MOTHER'S MAIDEN NAME <u>Emilie Neubert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>Mrs George H. Koenig Denton</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yr</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary myocardial infarction</u>		<u>2 yr</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Coronary thrombosis, 2-26-56 and 1-24-57</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 26, 19 56</u> , to <u>Jan 27, 19 58</u> , that I last saw the deceased alive on <u>Jan 27, 19 58</u> , and that death occurred at <u>7:05 P</u> , from the causes and on the date stated above.			
SIGNATURE <u>Paul Kurth</u>		DATE SIGNED	
M.D. <u>Denton, Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 31, 1959</u>	
NAME OF CEMETERY OR CREMATORY <u>Denton</u>		LOCATION (City, town, or county) (State) <u>Denton, Md.</u>	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <u>Arthur E. Kneass</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Walter Koenig Denton, Md.</u>	
DATE <u>FEB 3 '59</u>			



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CERTIFICATE OF DEATH

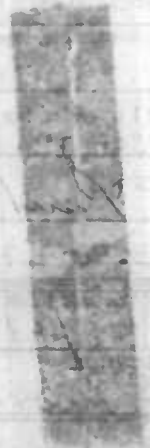
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CAROLINE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>WILLARD</u> Middle <u>EARL</u> Last <u>LANE</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>12</u> Year <u>19 59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 4, 1904</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT E. LANE</u>		14. MOTHER'S MAIDEN NAME <u>LINDA WARREN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Willard Lane Denton, wid.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension 3 yrs</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 20</u> , 19 <u>52</u> , to <u>Jan 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 12</u> , 19 <u>59</u> , and that death occurred at <u>9:40AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. Paul Knotts</u>		DATE SIGNED <u>Denton, Md</u>	
PHYSICIAN'S NAME (Type) <u>E. Paul Knotts M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Jan 14, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Denton, Md</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Varghese</u>		24. REC'D BY REGISTRAR DATE <u>JAN 20 '59</u>	
ADDRESS <u>Denton, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

CERTIFICATE OF DEATH

1937

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1900</u></p>		<p>4. Place of birth: <u>Arkansas</u></p>	
<p>5. Date of death: <u>1937</u></p>		<p>6. Place of death: <u>Arkansas</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Duration of illness: <u>10 days</u></p>	
<p>9. Name of physician: <u>Dr. J. H. Smith</u></p>		<p>10. Name of funeral home: <u>None</u></p>	
<p>11. Name of informant: <u>John J. Smith</u></p>		<p>12. Address of informant: <u>123 Main St, Little Rock, Ark.</u></p>	
<p>13. Signature of informant: <u>[Signature]</u></p>		<p>14. Signature of physician: <u>[Signature]</u></p>	
<p>15. Date: <u>1937</u></p>		<p>16. Place: <u>Arkansas</u></p>	



RECEIVED BY THE STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Items 1, 14 FilmG238 2-6-59 et

438

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		CAROLINE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		GREENSBORO	
c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Tribbetts Nursing Home	
3. NAME OF DECEASED (Type or print)		First Middle Last WILLIAM LEWIS MITCHELL	
5. SEX		M	
6. COLOR OR RACE		W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		JAN 12, 1874	
9. AGE (In years last birthday)		85 yrs.	
IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
RAILROAD		MARYLAND	
11. BIRTHPLACE (State or foreign country)		USA	
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME		ISAAC MITCHELL	
14. MOTHER'S MAIDEN NAME		Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
NO		(If yes, give war or dates of service)	
17. INFORMANT		Edw Gallagher Ridgely, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 1, 1956, to Jan. 21, 1959, that I last saw the deceased alive on Jan. 21, 1959, and that death occurred at _____ M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Charles H. Stonesifer, M.D.		Greensboro, Maryland 1-24-59	
PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial Jan 25, 1959		Greenmount Hillboro, Md	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Furness & Sons Denton		Hillboro, Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR JAN 29 '59	
Furness & Sons Denton		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>JOHN J. WILSON</i>		AGE <i>65</i>	
SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>12-15-1918</i>		PLACE OF DEATH <i>Home</i>	
CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
STATE <i>Md.</i>		COUNTRY <i>U.S.A.</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
DISEASE OR INJURY <i>Coronary Artery Disease</i>		IMMEDIATE CAUSE <i>Myocardial Infarction</i>	
PREVIOUS ILLNESS <i>None</i>		PREVIOUS INJURY <i>None</i>	
SIGNATURE OF PHYSICIAN <i>J. H. Smith</i>		SIGNATURE OF REGISTRAR <i>J. H. Smith</i>	
DATE OF SIGNATURE <i>12-15-1918</i>		DATE OF SIGNATURE <i>12-15-1918</i>	
PLACE OF SIGNATURE <i>Baltimore</i>		PLACE OF SIGNATURE <i>Baltimore</i>	
CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
STATE <i>Md.</i>		COUNTRY <i>U.S.A.</i>	

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD AS KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00432

439

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg		c. LENGTH OF STAY IN 1b 8 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION South Main St.		d. STREET ADDRESS Cambridge, Md. 0913.2	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Edward Mowbray		4. DATE OF DEATH Month Day Year Jan. 10, 1959 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1894
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) police and guard work detective co.		10b. KIND OF BUSINESS OR INDUSTRY E. New Market	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Mowbray		14. MOTHER'S MAIDEN NAME Emma Reeves	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Chas. Mowbray		Address Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Minim Pulmonary Hemorrhage 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary abuse DUE TO (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 8 ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-9- 19 59 , to 1-10- 19 59 , that I last saw the deceased alive on January 10, 1959 , and that death occurred at 1 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 126 Bloomingsdale Avenue DATE SIGNED ACTUAL SIGNATURE H. R. Trapnell M.D. Federalburg, Maryland PHYSICIAN'S NAME (Type) H. R. Trapnell, M.D. Federalburg, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/12/59	
22c. NAME OF CEMETERY OR CREMATORY E. New Market Cem.		22d. LOCATION (City, town, or county) (State) E. New Market, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey Williams		ADDRESS Federalburg, Md.	
24a. REC'D BY REGISTRAR JAN 14 1959		24b. REGISTRAR'S SIGNATURE Charles E. Kinn	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural				c. LENGTH OF STAY IN 1b 55 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Smithville Road				e. STREET ADDRESS Smithville Road			
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Tristram Middle Downs Last Nabb				4. DATE OF DEATH Month January Day 8 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 12, 1873	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Talbot County, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Downs Nabb				14. MOTHER'S MAIDEN NAME Mary Elizabeth Matthews			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Mrs. Robert O. Dulin, Federalsburg, Md. RFD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Atherosclerosis with 420.2 DUE TO Anginal Terminal attack Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Collapse. (c) 2 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec 28, 1958 , to Jan 7, 1959 , that I last saw the deceased alive on Jan 9 AM , 1959, and that death occurred at 9:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. E. Lennon M.D.				ADDRESS (Street, city or town, state) Federalsburg Md DATE SIGNED 1-9-1959			
PHYSICIAN'S NAME (Type) W. E. Lennon, M.D.				Federalsburg, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 11, 1959		22c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery		22d. LOCATION (City, town, or county) (State) East New Market, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DATE JAN 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro - Rural				c. LENGTH OF STAY IN 1b 5 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Irving's Chapel Road				e. STREET ADDRESS Irving's Chapel Road			
3. NAME OF DECEASED (Type or print) First Clayton Middle Andrew Last Nichols				4. DATE OF DEATH Month January Day 20 Year 19 59			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 6, 1899	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 59 Days 20 Hours 19 Min. 59		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Federalsburg, Md., R.F.D.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Louis H. Nichols				14. MOTHER'S MAIDEN NAME Sarah E. James			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-12-0988		17. INFORMANT Mary V. Nichols, 37 Cunard St., Boston, Mass.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 163X IMMEDIATE CAUSE (a) Carcinoma of the lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 2 , 19 59 , to Jan. 20 , 19 59 , that I last saw the deceased alive on Jan. 20 , 19 59 , and that death occurred at 2 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Greensboro, Md. DATE SIGNED 1-23-59							
ACTUAL SIGNATURE Charles H. Stonesifer M.D.				PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 23, 1959		22c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery		22d. LOCATION (City, town, or county) (State) Near Federalsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Framptom and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DATE JAN 30 1959		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

IT FRONTIERS—HEAD-TO-TOE TRAGEDY? CHAIRMAN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00435

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Caroline 442 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg - Rural c. LENGTH OF STAY IN 1b 15 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg - Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Reliance Road		d. STREET ADDRESS Reliance Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle Archibald Last Reagan		4. DATE OF DEATH Month January Day 1 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 24, 1883
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland Plastics, Inc. Dorchester Co., Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Archibald Reagan		14. MOTHER'S MAIDEN NAME Georgeanna (maiden name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Reginald A. Reagan, Cambridge, Maryland		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation - Smoke 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) 3rd Degree burns - 1/2 body (c) Exposure DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Bed Caught Fire from Cigarette	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 1-1 19 59 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Federalburg (County) Caroline (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dawson D. George M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dawson D. George		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 9, 1959	
22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		22d. LOCATION (City, town, or county) Cambridge, Maryland (State) 	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalburg, Maryland		24a. REC'D BY REGISTRAR JAN 12 '59	
		24b. REGISTRAR'S SIGNATURE Arthur E. Hays	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00436

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Ridgely</u>				c. LENGTH OF STAY IN 1b <u>50 Yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Rural Ridgely</u>			
f. STREET ADDRESS <u>None</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Taylor</u>				4. DATE OF DEATH Month Day Year <u>1 22 19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/18/1890</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>No Record</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mary E. Taylor</u>		Address <u>Ridgely, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 10</u> , 19 <u>58</u> , to <u>Jan. 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan. 22</u> , 19 <u>59</u> , and that death occurred at <u>6:50P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles H. Stonesifer</u> M.D.				ADDRESS (Street, city or town, state) <u>Greensboro, Md.</u>		DATE SIGNED <u>1-24-59</u>	
PHYSICIAN'S NAME (Type) <u>Charles H. Stonesifer</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulois</u>				ADDRESS <u>Greensboro, Md.</u>		24a. REC'D BY REGISTRAR <u>Jan 27 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>William L. King</u>			

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Ca roline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henderson	c. LENGTH OF STAY IN 1b 25 Yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Henderson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		d. STREET ADDRESS None	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mary Middle Elma Last Tzschoppe		4. DATE OF DEATH Month 1 Day 19 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/5/1871
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 87 Days 87 Hours 87 Min. 87	IF UNDER 24 HRS. Months 87 Days 87 Hours 87 Min. 87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H ousewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Wiloughby	
14. MOTHER'S MAIDEN NAME Martha Anders		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Harry Tzschoppe Henderson, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolus 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JAN 13, 19 59 to JAN 19, 19 59 , that I last saw the deceased alive on JAN 19, 19 59 , and that death occurred at 9:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) MARPLE AVE DATE SIGNED JAN 21 19 59 ACTUAL SIGNATURE Robert H. Wright M.D. GREENSBORO, MD PHYSICIAN'S NAME (Type) ROBERT H. WRIGHT MID GREENSBORO, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/23/59	22c. NAME OF CEMETERY OR CREMATORY Greensboro	22d. LOCATION (City, town, or county) (State) Greensboro, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulanger		24a. REC'D BY REGISTRAR DATE JAN 22 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
SEX		AGE		OCCUPATION	
MARRIAGE		EDUCATION		RELIGION	
BIRTH		DEATH		CAUSE OF DEATH	
MANNER OF DEATH		PERIOD OF ILLNESS		HISTORY OF PRESENT ILLNESS	
PREVIOUS ILLNESS		TREATMENT		POST-MORTEM EXAMINATION	
FAMILY HISTORY		SOCIAL HISTORY		LABORATORY EXAMINATIONS	
PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS		BACTERIOLOGICAL FINDINGS	
GROSS FINDINGS		HISTOLOGICAL FINDINGS		IMMUNOLOGICAL FINDINGS	
TOPOGRAPHICAL FINDINGS		FUNCTIONAL FINDINGS		OTHER FINDINGS	
CLINICAL COURSE		PROGNOSIS		TREATMENT	
FAMILY HISTORY		SOCIAL HISTORY		LABORATORY EXAMINATIONS	
PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS		BACTERIOLOGICAL FINDINGS	
GROSS FINDINGS		HISTOLOGICAL FINDINGS		IMMUNOLOGICAL FINDINGS	
TOPOGRAPHICAL FINDINGS		FUNCTIONAL FINDINGS		OTHER FINDINGS	
CLINICAL COURSE		PROGNOSIS		TREATMENT	